HOSPITAL FAX REPORTING
OF INCIDENTS AND ABUSE

GENERAL INSTRUCTIONS:

1. These instructions apply to reporting all hospital incidents, and suspected abuse, neglect, mistreatment and misappropriation of patient property under the Patient Abuse Law.

2. Complete a separate blank form for each occurrence following the instructions below.

3. Use the attached tables to enter a description for those items that are marked "see table."

4. Submit your completed report by fax to the Department immediately for (1) fires; (2) suicide; (3) serious criminal acts; (4) pending or actual strike; (5) serious physical injury or harm to a patient resulting from accident or unknown cause; and, (6) suspected abuse, neglect, mistreatment or misappropriation involving nursing home, rest home, home health, homemaker and hospice patients. **Notify the Department immediately by phone at 617-753-8150 of any deaths resulting from incidents, medication errors, abuse or neglect; and full or partial evacuation of the facility for any reason**. Submit other completed reports within seven days of the date of the occurrence of an incident seriously affecting the health and safety of patients.

5. Fax your completed report to the Department at **617-753-8165**.

LINE BY LINE INSTRUCTIONS

FROM: Please provide the name and address of the facility making the report.

DATE OF REPORT: Enter the date that you are submitting your report to the Department.

FOR ABUSE, NEGLECT, MISTREATMENT or MISAPPROPRIATION OCCURING IN NURSING HOME, REST HOME, HOME HEALTH, HOMEMAKER OR HOSPICE SETTING, NOT AT THE REPORTING HOSPITAL:

FACILITY/AGENCY NAME: Indicate the name of the provider at which the suspected abuse, neglect, mistreatment or misappropriation occurred.

ADDRESS: Indicate the address (city or town, if street address is not known) of the provider at which the suspected abuse, neglect or misappropriation occurred.

Please indicate the date and time of the occurrence. If you are not able to determine when the event occurred, state "unknown".

PATIENT INFORMATION: Please provide information here regarding the patient involved. The information reported here should reflect the patient's condition prior to the occurrence. If more than one patient was injured, or if one patient has injured another

patient, provide additional patient information under the narrative portion of the report or on an additional page. Please indicate:
NAME: The patient's first and last name.

AGE; SEX; ADMISSION DATE: Enter each for the named patient.

AMBULATORY STATUS: Select the term from Table #1, "Ambulatory Status", that most closely describes the patient's ability to walk.

ADL STATUS: Activities of Daily Living (ADLs) such as eating, dressing or personal grooming. Select the term from Table #2, "Patient ADL Status", that most closely describes the patient's ability to perform these functions.

COGNITIVE LEVEL: Select the term from Table #3, "Patient Cognitive Status", that best describes the patient's cognitive status at the time of the occurrence.

MENTALLY RETARDED/DEVELOPMENTALLY DISABLED: Indicate whether or not the patient is mentally retarded or developmentally disabled. If the resident is either, indicate the name of the Service Coordinator (mentally retarded) or Case Manager (developmentally disabled) assigned to the patient, if known.

RACE/ETHNICITY: Indicate the Patient's Race and Ethnicity. Complete the Hispanic Indicator. The rules for coding race and ethnicity and the Hispanic Indicator are the same as used by the Division of Health Care Finance and Policy in its inpatient discharge data submission regulations. See the instructions in the Electronic Records Submission Specification:
http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/114_1_17_hdd_data_specs.doc
The details are on page 25 of this document.

DPH OCCURRENCE TYPE: For all reports, select the term from Table #4, "Occurrence Type", that best describes the occurrence you are reporting. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report.

SERIOUS REPORTABLE EVENT: Indicate whether or not this is a report of a "serious reportable event" as described in the current National Quality Forum (NQF) list of serious reportable events (SRE). If it is an SRE, check of the type of SRE on the table on page 2.
For additional information regarding NQF see
http://www.qualityforum.org/pdf/news/prSeriousReportableEvents10-15-06.pdf

TYPE OF HARM: Select the term from Table #5, "Type of Harm", that best describes the harm or injury that resulted from the occurrence. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report. Note that harm includes psychological injury as well as physical harm, and SHOULD NOT BE DESCRIBED AS "NONE" SIMPLY BECAUSE THERE WAS NO PHYSICAL HARM.

BODY PART AFFECTED: Use terms such as "arm", "foot", etc.; indicate left or right when it applies.

PATIENT'S ACTIVITY AT TIME OF OCCURRENCE: Select the term from Table #6, "Patient's Activity" that best describes the patient's activity at the time of the occurrence. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report.

PLACE OF OCCURRENCE: Specify where the event occurred. Examples would include: "patient's room", "dining room", "shower room", or any other short phrase that specifies the type of setting in which the occurrence took place.

WHAT EQUIPMENT, IF ANY, WAS BEING USED AT TIME OF OCCURRENCE: Specify if any equipment was in use, such as "Hoyer lift", or "walker".

ANY SAFETY PRECAUTIONS IN PLACE: Check the "yes" or "no". If "yes", describe the precautions that were in place.

NARRATIVE: Describe fully what occurred. Indicate who, what, when, where, why and how what is being reported occurred. Include information on how any person injured was treated. If there were any unusual circumstances involved, describe these fully.

CORRECTIVE MEASURES NARRATIVE: Describe what actions have been taken in response to the occurrence.

GENERAL INFORMATION: Please indicate your name and title, as the person preparing this report, a phone number at which we can contact you if we need additional information, and the date and time of the occurrence. If you are not able to determine when the event occurred, state "unknown".

STAFF PERSON IN CHARGE OF FACILITY AT TIME OF OCCURRENCE: Indicate who was present and in charge at the facility (not on the unit) when the occurrence reported happened.

NOTIFICATION: Indicate whether or not the patient's family and physician, and police were notified. Provide the name of the physician notified.

WITNESS INFORMATION: List the name and title for individuals who saw or heard what occurred. Indicate if any of witnesses were directly involved in what occurred. Other patients, visitors and volunteers should be listed as witnesses if they have direct knowledge of what occurred.

ACCUSED INFORMATION: When reporting suspected abuse, neglect or misappropriation, indicate the name of the accused, a phone number at which the accused can be contacted, if the accused is a nurse, nurse aide or other licensed professional please indicate the individual's license or registration number. Check the appropriate block if you are not reporting abuse, or the identity of the person(s) suspected of abuse, neglect or misappropriation of a patient's money or belongings is unknown. If more than one individual is suspected, indicate on an additional sheet the other individual's names, a phone number at which they may be contacted, and if any person was acting as a nurse aide, home health aide or homemaker.

REPORTING TABLES:

Table #1: Ambulatory Status

Independent
Supervised
Ambulates with Assistance
Dependent/Assist
Walks with Cane/Walker
Wheels Self
Wheelchair
Bedfast
Other
Unknown

Table #2: Patient's ADL Status

Independent
Supervised
Dependent
Requires verbal cues
Requires physical assist
Other
Unknown

Table #3: Patient's Cognitive Status

Alert/Oriented
Confused
Alzheimer's
Developmentally Delayed
Dementia
Comatose
Mental Illness/Psych History
Unknown
Other

Table #4: Incident/Allegation Type

Abuse by Staff – Physical
Abuse by Staff – Sexual
Abuse by Staff – Verbal
Abuse by Visitor/Resident/Other
Abuse – Policies and Procedures
Administration
Advocacy Office Violation
Beds Out of Service
Blood and Transfusion Services
Change in Beds/Services
Change of Location
Change of Ownership
Choking/Aspiration Incident

Table #4: Incident/Allegation Type (cont.)

Closure
Criminal Act
Death
Dental Services
Dietary Services
Elopement/Missing Person
Emergency Care
Epidemic/Disease
Equipment Malfunction
Fall – Fracture
Fall – Laceration
Fall – Other
Fire
Fraud/False Billing
HCFRS Enrollment
Infection Control
Injury – Burn
Injury – Fracture
Injury – Laceration
Injury – Other
Laboratory Services
Local Laws Violation (permits, etc.)
Maternal Death
Medical Records
Medication Incident
Misappropriation
Missing Personal Property
Neglect
Notification of Records Destruction
Nursing Services
Pharmacy Services
Physical Environment
Physician Services
Pressure Ulcer
Quality of Care/Treatment
Quality of Life
Rehabilitation Services
Resident/Patient Rights
Resident/Patient to Resident/Patient Incident
Restraint
Staff Credentialing
Strike/Pending Strike
Suicide/Suicide Attempt
Surgical Services
Transfer/Discharge
Unknown/Other

Table #5: Type of Harm

Bruise/Hematoma
Burn
Care Not Provided
Confinement
Death
Decline in Condition
Dislocation
Emotional Harm/Upset
Fracture
Funds
Infection
Laceration
No Harm
Other – Please Describe
Pain
Pressure Ulcer
Property
Quality of Care
Reddened Area
Rough Handling
Skin Tear
Unknown
Unwelcome Sexual Contact/Advance

Table #6: Patient's Activity

Ambulating
Crowded Area
Getting Out of Bed
Getting Up From Chair
Other – Please Describe
Reaching
Standing/Sitting Still
Standing
Toileting
Transfer/Assist
Unknown

HOSPITAL FAX REPORT FORM

TO: INTAKE STAFF
DEPARTMENT OF PUBLIC HEALTH, DIVISION OF HEALTH CARE QUALITY
FAX NUMBER: 617-753-8165

FROM:

Hospital Name: _____

Address (Street): _____

Address (City/Town): _____

Report prepared by (Name/title): _____

Telephone #: _____

DATE OF REPORT: _____ NUMBER OF PAGES: _____

DATE OF OCCURRENCE: Month: _____ Day: _____ Year: _____

TIME OF OCCURRENCE: _____ am_____ pm_____

*IF ABUSE, NEGLECT, or MISAPPROPRIATION IN A **NURSING HOME, REST HOME, HOME HEALTH, HOMEMAKER, OR HOSPICE AGENCY** AND **NOT** THE REPORTING HOSPITAL:*

Facility/Agency Name: _____

Address: _____

PATIENT INFORMATION:

Name: First: _____ Last: _____

Age: _____ Date of Birth: _____

Sex: Male _____ Female _____

Admission Date: Month: _____ Day: _____ Year: _____

Ambulatory Status (See table #1): _____

ADL Status (See table #2): _____

Cognitive Level (See table #3): _____

Developmentally Disabled: ____ Yes ____No.
If yes, Service Coordinator or Case Manager (if known): _____

RACE:
___Asian
___Black/African American
___ White
___ American Indian/Alaska Native
___ Native Hawaiian or Other Pacific Islander
___ Unknown/Not Specified
___ Other Race (specify) _____

HISPANIC INDICATOR
__Patient is Hispanic/Latino/Spanish
__Patient is not Hispanic/Latino/Spanish

ETHNICITY: Please check all that apply:

___Cuban	___ Asian Indian	___ Honduran
___Dominican	___ Brazilian	___ Japanese
___ Mexican/Mexican American/Chicano	___ Cambodian	___ Korean
___ Puerto Rican	___ Cape Verdean	___ Laotian
___ Salvadoran	___ Caribbean Island	___ Middle Eastern
___ Central American (not specific)	___ Chinese	___ Portuguese
___ South American (not specific)	___Columbian	___ Russian
___ African	___ European	___Eastern European
___ African American	___ Filipino	___ Vietnamese
___ American	___ Guatemalan	___ Other Ethnicity
___ Asian	___ Haitian	___ Unknown/Not Specified

DPH Incident/Allegation Type (See table #4):_____

Type(s) of Harm (See table #5): _____

Body Part(s) Affected: _____ L:_____ R: _____

Patient's activity at time of occurrence (See table #6): _____

_____

Place of Occurrence: _____

What equipment, if any, was being used at time of occurrence? _____

_____

NARRATIVE QUESTIONS:
Please ATTACH narrative answers to the following questions on a SEPARATE page(s).

1. Were there any safety precautions in place? Yes_____ No_____
If yes, describe what precautions were in place:

2. NARRATIVE: (Please address the following: What happened? What factors contributed to the occurrence? Any relevant information which establishes cause? Have there been similar incidents in the past? How were the injuries treated?)

3. Were there any unusual circumstances involved? Yes_____ No_____ If yes, please describe.

4. CORRECTIVE MEASURES NARRATIVE – Please address the following:

N/A - Incident occurred with another provider _____.
Was there an internal investigation: Yes_____ No_____ If No - why? If yes - what are the investigation findings?
What action was taken with regard to: Patient?; Staff?; Facility practice? What is the patient's current status?
What corrective action taken regarding equipment involved, if applicable?

STAFF PERSON IN CHARGE OF FACILITY AT TIME OF OCCURRENCE:

N/A (Incident occurred with another provider):_____

Name: Title: Directly Involved:
_____YES_____NO_____

NOTIFICATION:

Was family notified: Yes_____ No_____

Was MD notified: Yes_____ No_____

Name of MD if notified: _____

Were police notified: Yes_____ No_____

WITNESS INFORMATION:

(Check here if unwitnessed: _____)

Name: Title: Directly Involved:

_____YES_____NO_____

_____YES_____NO_____

ACCUSED INFORMATION:

(Check here if unknown or not applicable: _____)

Name: _____

Telephone: (_____) _____-_____

AIDE ___; RN/LPN ____

If RN/LPN or other licensed individual, indicate license #:_____

SERIOUS REPORTABLE EVENT:
Is this a serious reportable incident (SRE) as defined by NQF ____ Yes ____No.

SRE TYPE: Indicate the type(s) of SRE below:

1. SURGICAL OR INVASIVE PROCEDURE EVENTS
___ Surgery or other invasive procedure performed on the wrong site
___ Surgery or other invasive procedure performed on the wrong patient
___ Wrong surgical or other invasive procedure performed on a patient
___ Unintended retention of a foreign object in a patient after surgery or other invasive procedure
___ Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient

2. PRODUCT OR DEVICE EVENTS
___ Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
___ Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
___ Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

3. PATIENT PROTECTION EVENTS
___ Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.
___ Patient death or serious injury associated with patient elopement (disappearance)
___ Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting

4. CARE MANAGEMENT EVENTS
___ Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
___ Patient death or serious injury associated with unsafe administration of blood products
___ Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
___ Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
___ Patient death or serious injury associated with a fall while being cared for in a healthcare setting
___ Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
___ Artificial insemination with the wrong donor sperm or wrong egg
___ Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
___ Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

5. ENVIRONMENTAL EVENTS
___ Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
___ Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
___ Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
___ Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

6. RADIOLOGIC EVENTS
___ Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

7. POTENTIAL CRIMINAL EVENTS
___ Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
___ Abduction of a patient/resident of any age
___ Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
___ Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

SRE ATTESTATION: (please check boxes to confirm the statements):

☐ This report is being made within 7 calendar days of the discovery of the event.

☐ The patient or patient's representative has been notified verbally and in writing about:

- the occurrence of the SRE including unanticipated outcomes of care, treatment and services provided as the result of an SRE
- the hospital's policies and procedures and documented review process for making a preventability determination
- the option to receive a copy of the report filed with the Department

☐ A copy of this report is being provided to any responsible third-party payer.

PATIENT INSURER: _____

INSURANCE IDENTIFICATION NUMBER: _____

SRE REPORT UPDATE: If this is an SRE, the following update to this report is required within 30 days of the initial reporting

REPORTING HOSPITAL: _____ DATE OF OCCURRENCE: _____

PATIENT NAME _____

DATE OF REPORT: _____

Please check the boxes below to confirm the following statements:

☐ This updated report is being made within 30 days of the initial reporting of the event.

☐ The patient or patient's representative has been provided with a copy of this updated report.

☐ Any responsible third party payer has been provided with a copy of this updated report.

PATIENT INSURER: _____

INSURANCE IDENTIFICATION NUMBER: _____

PREVENTABILITY DETERMINATION NARRATIVE: [Attach additional pages as needed.]

DECISION TO SEEK PAYMENT:

☐ The hospital is seeking payment for services provided as a result of this SRE.

☐ The hospital is **not** seeking payment for services provided as a result of this SRE.

☐ The patient is a Medicare patient. Medicare rules apply.